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ABSTRACT

The document presents an analysis of recent literature on the deinstitutionalization of emotionally disturbed persons. Discussed are opposing views with emphasis on the idea of reliance on community resources and the present trend toward the provision of a continuum of treatment alternatives. Brief sections cover issues related to such problems as the selection of patients for community care, the treatment course of patients in the community, financial and fiscal problems, legal and quasi-legal problems, and accountability. The author describes basic concepts in the functionalist approach to social forms and the application of these concepts to the functions of asylum and custody. It is concluded that the deinstitutionalization movement can best meet its goals through the avoidance of territorial arguments and the consideration of such programs as hospital-based outpatient care, brief hospitalization, and community outreach. A bibliography of approximately 480 references is provided. (IM)

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Deinstitutionalization: An Analytical Review and Sociological Perspective

Leona L. Bachrach, Ph.D.

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PREFACE

It is rare today to read a professional or lay article in the field of mental health that does not in some way depart from, allude to, and/or offer criticisms of or suggestions for implementing the deinstitutionalization of mental patients. Rarely defined in a precise manner, the very term deinstitutionalization evokes intense emotional and partisan responses. It is the verbal referent of a movement in mental health which has for over a decade preoccupied clinicians and researchers, citizens and politicians. The literature so abounds with articles concerning the various aspects of deinstitutionalization, that it would be very difficult indeed to present a systematic and coherent summary of all that has been written.

Originally, this work was intended as a summary review of the literature dealing with the issues in deinstitutionalization. As I began, however, to accumulate an ever-lengthening bibliography, it became clear to me that still another narrative review of issues could be of only marginal value; somehow, it seemed that it had all been said before. Gradually, but firmly, the recognition grew that both the deinstitutionalization movement and the literature that discusses it are plagued by a common problem: the absence of a clearly outlined theoretical framework. The more I began to understand the dimensions of this deficit, the more appropriate it seemed that the present study should in some way attempt to go beyond a mere enumeration-*cum*-discussion of the issues surrounding deinstitutionalization. It should, instead, have as its major purpose the attempt to tie together in a coherent and meaningful way those questions that have already been raised and those insights that have already been proffered, in the hope that such synthesis will lead to a kind of understanding that can be used by planners and program implementers of the future.

Accordingly, this work is to be regarded as an analytical review and theoretical synthesis of the *issues* in deinstitutionalization. It is not, *per se*, a comprehensive review of the literature. The bibliography is extensive, but it is not "complete." Because it would be extremely difficult, and probably not very productive, to include *all* deinstitutionalization references in the bibliography, I have selected for inclusion those writings—both professional and lay—which support or illustrate points I wish to make in the analytical review.

My training as a sociologist has predisposed me to interpret the literature in certain ways, and I have utilized some of the insights of other sociologists to help me formulate my theoretical conception of the issues in deinstitutionalization. I should like to make it clear, however, that I do not feel that a sociological approach is, *sui generis*, the correct way to view the issues. I feel, rather, that the deinstitutionalization movement should be studied from a variety of perspectives. It is such a complex phenomenon, that there must be many levels of productive analysis, and a sociological approach is but one of several possible frameworks. The basic consideration at this point is to stop looking at deinstitutionalization as if it is made up of discrete problems begging for rhetorical commentary and to start looking at it in a new way. The new perspective must represent an effort to understand *why* the many problems are occurring, and it must attempt to explain the interrelationships among these problems.

In summary, this work is to be regarded very much as a first step in the systematic understanding of the deinstitutionalization movement and of the issues that have surrounded it. In serving as a basis for future investigation, it will doubtless raise more questions than it answers. Hopefully, however, these new questions—unlike the old—will be of a kind that can be translated into action.

CONTENTS

	Page
Preface	iii
I. INTRODUCTION	1
Toward a Definition of Deinstitutionalization	1
A Sociological Perspective on Deinstitutionalization	2
Scope of Study	2
II. BACKGROUND	4
Polarization: Opposing Views	6
De-Polarization: Moderation of Views	8
III. SUMMARY OF ISSUES IN DEINSTITUTIONALIZATION	10
A Taxonomy of the Issues in Deinstitutionalization	11
The Issues Examined	11
Issues related to the selection of patients for community care	11
Issues related to the treatment course of patients in the community	12
Issues related to the quality of life of patients in the community	13
Issues related to the greater community	13
Financial and fiscal issues	14
Legal and quasi-legal issues	14
Informational issues and accountability	15
Additional issues resulting from the process of deinstitutionalization itself	16
Synthesis	17
IV. A FUNCTIONALIST PERSPECTIVE	18
Basic Concepts in the Functionalist Approach	18
Application of Concepts: the Functions of Asylum and Custody	19
Application of Concepts: Additional Functions	20
V. DISCUSSION	22
VI. CONCLUSIONS	24
References	27

I. INTRODUCTION

"There is a serious, one might even say schizophrenic, contradiction between two of the most important trends in present day community mental health. On the one hand there is a mass exodus of long-term psychiatric patients from the State Hospitals with the assumption that they will be cared for by community mental health programs. On the other hand, the trend in community mental health is toward programs which tend to exclude long-term patients, that is, intensive care programs with emphasis on crisis intervention."

—H. Richard Lamb, 1975

TOWARD A DEFINITION OF DEINSTITUTIONALIZATION

In a statement concerning deinstitutionalization, Bertram Brown (1975), the Director of the National Institute of Mental Health, has provided an operational definition of the term. He has described three essential components of deinstitutionalization: (1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment; (2) the release to the community of all institutional patients who have been given adequate preparation for such a change; and (3) the establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community. Brown's statement is a description of an ideal. It expresses goals which, at this time, are still to be achieved. As a definition of what deinstitutionalization *should* or *might be*, it is an eloquent statement; as a definition of what deinstitutionalization *is*, it is still anticipatory.

In practice, the term deinstitutionalization is used in the literature to refer to a broad scope of patient-connected events, ranging from carefully planned local efforts to achieve the ideal expressed by Brown to the mass release of patients to communities as State hospitals have been "phased out" or closed. In some of the latter instances, patient release has been accompanied only by the most minimal pre-release patient preparation or planned community support. Almost always, in the literature, the term is used vaguely. Even some of the excellent treatises on the consequences of deinstitutionalization have failed to define it precisely. Sometimes the term appears to be used synonymously with "community mental health"—another movement which has paralleled the deinstitutionalization movement in time. Both have responded to the same social forces and are, in fact, philosophically very close relatives (Goldman 1976). However, the community mental health movement is broader in scope, for it concerns, in addition to the treatment of the noninstitutionalized mentally ill, the treatment of other individuals who would not be considered potential candidates for institutionalization (Dinitz and Beran 1971; Simon 1975). The community mental health movement is also concerned with providing a range of indirect services, aimed at the prevention of mental illness, which are not ordinarily considered to be within the scope of traditional activities conducted at mental hospitals (Wagenfeld 1972).

For purposes of the present study, deinstitutionalization may be understood as a process involving two elements: (1) the eschewal of traditional institutional settings—primarily State hospitals—for the care of the mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals. There are, actually,

two components of the deinstitutionalization process: the removal of persons who have already been hospitalized from their institutional environments and their transfer into the community; and the prevention of hospitalization of those persons who might be considered potential candidates for institutionalization.

Deinstitutionalization is, however, more than a process concerned with the locational aspects of patient care. It is also the expression of a philosophy rooted in an era of social and political reform which strongly emphasizes peoples' self-determination and their right to control the forces that affect them (Hersch 1972). It is important to understand this aspect of deinstitutionalization. Were only the locational aspects of patient care at issue, the movement might have caused only a minimum of controversy which could be relatively easily negotiated and resolved. But the movement in fact calls for very basic and fundamental changes in patterns of life deeply embedded in the American culture. Because of this, deinstitutionalization has "become the focus of an emotional debate" (Anonymous 1975*e*), which is characterized by polarized attitudes and resistance to compromise.

A SOCIOLOGICAL PERSPECTIVE ON DEINSTITUTIONALIZATION

Brown (1975) has pointed out that "the very term deinstitutionalization has become controversial, with conflicting connotations in different contexts" and that perhaps "the time has come to look for more appropriate terms." The present study, however, adopts a different position. The vagueness of the term notwithstanding, deinstitutionalization is connotative of a sociological process, and, in this sense, it is on mark. The sociologist, Kingsley Davis (1949, p. 71), has defined an institution as a "set of interwoven folkways, mores, and laws built around one or more functions." In short, an institution may be viewed in two different ways: as an established *place*, such as a long-term care mental hospital, or as an established *set of social patterns*, such as the totality of artifacts and practices society has adopted for the care of its mentally disabled population. It is in the latter sense that the term deinstitutionalization, when used in reference to the mentally ill, has greatest value. It implies the breakdown of a social system, of established patterns of social control which determine how the mentally ill should be viewed, what their status (position) in society is, what rights and obligations society has in reference to them, and what rights and obligations they have in reference to society.

In the present study, the terms institution, institutionalization and deinstitutionalization will be used primarily in the popular sense—that is, to refer to movements of patients in and out of mental hospitals. However, the terms will also be used at times in the sociological sense, as the author knows of no alternative terminology which conveys quite the same meaning. The specific usage of these terms should be apparent from the context in which they occur.

SCOPE OF STUDY

This study proceeds from the basic assumption that the promise of the deinstitutionalization movement—i.e., the enhancement of mental health services delivery through the provision of community-based facilities—can best be realized if the problems which it has encountered are recognized and acknowledged. Only through such appraisal can the problems be overcome. The basis for this work is a review of the literature concerned with the deinstitutionalization of mental patients. That review has resulted in the author's adoption of the position that not enough theoretically systematic attention has been paid to the process of deinstitutionalization. This has generated serious obstacles to the understanding of the process and of the issues related to it. Without a theoretical framework, writings have tended to contain, for the most part, a jumble of disparate facts and guesses, interspersed with strongly worded partisan stands. The resultant confusion has been sufficiently overwhelming to be counter-productive. Instead of receiving constructive criticism directed toward resolving issues in a practical way, the movement has found itself bogged down by seemingly insoluble problems.

It is the purpose of this work to describe the issues in deinstitutionalization concisely and systematically and to examine them with the assistance of a theoretical framework. The framework to be used is functionalist in nature and is based on insights provided by an anthropologist (Malinowski 1945), a semanticist (Hayakawa 1949), and several sociologists (Chinoy 1954; Crawford 1973; Johnson 1960; Merton 1957). A fundamental and underlying assumption is that many of the problems connected with deinstitutionalization are closely

related to a general failure, first, to understand and/or pay adequate attention to the unique position of the mental hospital in American culture, and, second, to make sufficient allowances for this uniqueness in the process of planning for social change.

At the conclusion of the text is a bibliography of citations from the professional and lay literature dealing with deinstitutionalization of the mentally ill and related topics. In no sense is this bibliography intended to be "complete." The body of literature is so vast and has taken such a variety of directions that any effort to include all writings would be doomed to failure. This study does, however, aim at reviewing broadly and summarizing generally the major issues treated in the literature. To this end, selections have been included in the bibliography for their relevance to points made in the text. Citations have generally been limited to writings from the past decade, but occasional earlier works have also been included in instances where they are especially relevant to, or strongly reinforce, particular points under discussion. In addition, a number of references not dealing with deinstitutionalization *per se*, but relevant to the sociological analysis of the materials reviewed, have been included in the bibliography.

II. BACKGROUND

"Characteristic of each humanitarian movement are four distinct periods. The first is a period of innovation or new ideas. This peaks rapidly after the initial outburst of enthusiasm, as the community mental health movement did between 1965 and 1970. The peak is followed by a period of criticism and then a time of retrenchment. The four periods are thus innovation, peaking, criticism, and retrenchment."

—Trevor D. Glenn, 1975

Recent years have witnessed the gradual phaseout of a number of mental hospitals and the complete closing of others,[1] while the utilization of local community-based services has steadily increased. That there has been a growing trend toward the treatment of the mentally ill in their home communities is apparent from utilization statistics. In 1955, about half of the psychiatric patient care episodes in the Nation were in State mental hospitals, as contrasted with about one-fifth in 1971. Outpatient services accounted for only 23 percent of psychiatric patient care episodes in 1955 but for 42 percent in 1971. Federally funded community mental health centers, which did not even exist prior to the passage of the Community Mental Health Centers Act of 1963, accounted for 19 percent of psychiatric patient care episodes in 1971 (Pollack and Taube 1975; Redick 1975).

Paralleling the reduction of patient care episodes in State hospitals has been a dramatic decrease in the size of State hospital resident populations. The number of resident patients in State mental hospitals, which peaked at 558,992 in 1955, has been decreasing ever since. During a period of 9 years alone, starting with the 1963 Presidential message on mental health, the resident population of State hospitals decreased by 45 percent (from 504,604 to 275,995). One of the critical elements in this decrease has been the smaller number of first admissions aged 65 and over and the correspondingly heavier reliance on nursing home and other residential facilities for this long-stay population. Another factor has been the widespread use of psychoactive drugs in the treatment of inpatients, which has made possible greatly shortened hospital stays, as well as the release of patients who might never otherwise have been considered for discharge into the community.

At the same time that the resident population of State hospitals has decreased in size, the number of admissions to these hospitals has, in general, increased.[2] Thus, more patients have been admitted for shorter periods of time. Although the general diagnostic distribution of the resident population at these institutions has not changed appreciably over these years—about half the resident patients have been and continue to be schizophrenic—there has been a marked change in the diagnostic composition of admissions. In 1962, for example, 21 percent of first admissions to State hospitals had diagnoses of schizophrenia, and 15 percent had diagnoses of alcohol disorders. In 1972, corresponding percentages were 14 percent and 26 percent, respectively.

[1] A number of references describe and discuss phasedowns, phaseouts, and closings of State hospitals. Selected examples are: Cumming and Markson (1975); Ishiyama (1974); Keenan (1974); Khan and Kaplan (1974); Markson (1976); Markson and Cumming (1974); Marlowe (1974); McDonald (1974b); Place and Weiner (1974); Schultz, Lyons and Nothnagel (1975); Sills (1975); State of California (1973); Weiner, Bird, and Associates (1975).

[2] Actually, with the year 1972, a reversal in statistical trends is noted. Taube (1974) reports that admissions to State mental hospitals during both 1972 and 1973 showed decreases over the previous years.

These statistics reflect a changing philosophy of mental health care in the United States—a philosophy which, in recent years, has undergone rapid and major revision. Outpatient care has been favored over inpatient treatment. And when inpatient treatment has been indicated, the emphasis has been in the direction of care in short-term facilities, such as general hospitals and community mental health centers, instead of long-term mental institutions.

There has been a growing conviction among many mental health professionals that the removal of the mentally ill individual from "normal home and community ties" (Schwartz 1971) reduces his chances for effective treatment. Thus, the new philosophy in mental health care embraces the goal of avoidance of hospitalization whenever possible and the "replacement of custodial philosophies by therapeutic ones" (Schwartz 1971). Because institutionalization is perceived as "banishment" (Rusk 1972)—because it is viewed as fostering regression among patients (Herz 1972)—there is a strong feeling that the provision of services on any basis other than institutionalization is superior to a hospital experience. Although access to adequate mental health services is understood to be a basic right of all individuals, these services should, ideally, be provided without exposing patients to the stigma associated with traditional custodial mental health care. In addition, the noninstitutionalized patient living in the community has the opportunity to benefit from the salubrious effects of social contact with sympathetic and supportive relatives and friends (Kramer 1967).

These philosophical principles, coupled with evidence that "hospitalization begets more hospitalization" (Schwartz 1971),[3] lead logically to a strong commitment to the notion that the role of the mental hospital in the treatment complex must be revamped, if not eliminated. With patient care occurring in a familiar, relatively stigma-free home environment, the patient is more likely to be understood and to see himself as a participating member of his own home community, rather than as a stigmatized expatriate.

This entire philosophy is thrown into sharp relief by an emerging development—the introduction of so-called brief hospitalization units for psychiatric patients in some localities (Caffey, Galbrecht, and Klett 1971; Herz, Endicott, and Spitzer 1975; Rhine and Mayerson 1971; Schwartz 1971; Schwartz, Weiss and Miner 1972; Walker, Parsons and Skelton 1973; Yarvis 1975). Typically, these units are administratively connected with emergency services in general hospitals, although they may be tied to other services. They admit patients for brief stays rarely exceeding 4 or 5 days, during which a judgment is made regarding further disposition of the case—that is, discharge or transfer to an inpatient facility. Patients who are discharged directly from these units may to some extent avoid the stigma associated with psychiatric hospitalization, as they frequently are technically not counted as having occupied psychiatric beds.

Changes in service delivery philosophy have, of course, not occurred in an ideological vacuum. To the contrary, they may be understood as having had what might be called a natural history of their own: they have come about as logical responses to what may simply be labelled "the times." Feldman (1974) aptly points out that changes in treatment patterns have occurred "not because our patients are really any different, but because we are." In short, there has in recent years been a strong civil libertarian emphasis on the rights of mental patients (Schmolling 1975; Slovenko and Luby 1974).

Hersch (1972) provides a penetrating discussion of the ideological bases of deinstitutionalization.[4] He points out that, typologically, "the times" may be characterized in one of two ways—either as an era of social-political conservatism or as an era of social-political reform. The former favors a view of problems as having their bases in individuals, while, in the latter, the locus of problems is the environment. Accordingly, in the former case, emphasis for amelioration is on changing the individ-

[3] There is a substantial amount of statistical evidence for this generalization. Selected examples are provided in: Anthony et al. (1972); Buell and Anthony (1973); Fontana and Dowds (1975); Franklin, Kittredge and Thrasher (1975); Rosenblatt and Mayer (1974). Kirk (1976) provides an interesting perspective on readmission statistics in his report of a study of Kentucky State hospital dischargees. He finds that patients receiving no aftercare community services and those receiving substantial aftercare community services are the least likely candidates for readmission. He concludes: "Aggregating all of those who received aftercare apparently obscures the fact that those who receive some, but not much, aftercare, are the ones with the highest readmission rate."

[4] Selected additional references which amplify the ideological forerunners of the deinstitutionalization movement are: Felix (1964); Joint Commission on Mental Illness and Health (1961); Macht (1974); Rubins (1974a); Scherl (1974); Schwartz and Schwartz (1964).

ual; in the latter case, greater weight is placed upon modifying the environment.

The deinstitutionalization movement is clearly the outgrowth of an era of social-political reform. Greenblatt (1975) writes of the "rise of social psychiatry" during the second half of this century, which is reflected in "planning for ways and means of serving all the citizens... without regard to race, color, creed, or ability to pay." To illustrate Greenblatt's point, consider this quotation from a recently released position paper prepared by the Director of the Horizon House Institute (Rutman 1976, p. 2):

> Several basic issues underlying the concern for community-based—as opposed to institutional—care for the mentally disabled should be noted at the outset. First, a major proportion of all persons now in mental institutions, or those who will be hospitalized in the future, neither need nor benefit from long-term extended inpatient care. Second, there is reliable evidence that patients who remain in institutions for extended periods experience a variety of debilitating effects, and that the cumulative results of long-term confinement—a condition or state often referred to as institutionalization—is more damaging to the individual's mental health and well-being than the problem which required entering the hospital in the first place. Finally, for large numbers of present and future hospital patients, return to normal social functioning can only be accomplished if there are developed a variety of community-based residential facilities which can provide an atmosphere in which such persons can feel secure and accepted by peers, can improve skills of daily living, and can be helped to find their niche in the normal environment.

However, dominance of a reform ideology in a democracy does not preclude the strong co-existence of a conservative ideology. Steinhart (1973), in pointing this out, asks whether the pendulum may not have swung too far in the direction of community care. He writes:

> The original theme of keeping patients at home whenever possible has become ritualized into keeping patients completely out of the state hospitals, and even keeping them out of *any* mental hospital. Unfortunately, there are times when patients need to be hospitalized, whether in a state hospital or elsewhere.

Rieder (1974) states:

> The State mental hospital system, and the patients in it, are in danger of being "phased out" without an effective alternative source of care being available. It is a ridiculous abrogation of our responsibility if psychiatrists and other mental health professionals allow the existing poor treatment of mental patients to be replaced with something even worse.

POLARIZATION: OPPOSING VIEWS

The most cursory examination will show that the literature abounds with horror-story descriptions of the conditions of life inside mental hospitals. Not only have the physical conditions in these places been assailed, but so has the intense dehumanization—the "feeling that one is isolated from others and is regarded as a thing rather than as a person" (Leventhal 1975, p. 20)—experienced by the patient. Perhaps more penetratingly than any other recent writer, Rosenhan (1973), in summarizing the experiences of eight pseudopatients at 12 different mental hospitals, has painted a grim verbal picture of the depersonalization experienced by the patient in the mental hospital:

> Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment. He is shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but may only respond to such overtures as they make. Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. His personal history and anguish is available to any staff member (often including the "grey lady" and "candy striper" volunteer) who chooses to read his folder, regardless of their therapeutic relationship to him. His personal hygiene and waste evacuation are often monitored. The water closets may have no doors.

Rosenhan continues, "At times depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account," and provides this episode to illustrate his point:

> A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn't notice us.

Similarly, one finds damning descriptions of the plight of deinstitutionalized mental patients who are residing in the community. A strongly worded

and urgent statement is presented by Slovenko and Luby (1974)[8]:

> Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city. It is true that many persons in institutions have been dehumanized through neglect and the failure of society to meet their needs, but the second wrong of turning them back into a so-called community will not make a right. In today's world, neglect in the community dwarfs neglect in hospitals.

An example of what Slovenko and Luby mean is described in a paper by Wolpert, Dear and Crawford (1974), who write about the fate of deinstitutionalized patients in a section of San Jose, California, where approximately 10 percent of the population is composed of "discharged patients who are indolent and living in board and care facilities." The authors state:

> While there is little or no evidence to suggest that the residents are mistreated or exploited by the operators [of the residential facilities], there is ample evidence of inadequate community facilities for their further rehabilitation, recreation or other support systems. At least half of the residents are not employable and their daily routine largely involves confinement to their home watching television and drinking beer. Some of those who are employable have found employment or do become involved in county, religious, university or other volunteer programs which have been set up for their use. They may be seen walking in the streets, sitting in the laundromat or cheap cafes, and some are recognizable by the characteristic "drug shuffle," bowed head and shabby appearance.

Other writers—for example, Anderson (1974); Becker and Schulberg (1976); Chu and Trotter (1974); Greenblatt and Glazier (1975)—report evidence of financial exploitation of expatients by community caretakers with whom they come into contact.

In short, the deinstitutionalization movement has, since its inception, been characterized by a polarization in attitudes—a process not unusual in circumstances where social change involves issues with emotional overtones. A description of the polarization process is found in sociological theory:

> Necessarily public issues tend to be phrased in dichotomous terms—e.g., war or peace, protection or free trade, prohibition or saloons, freedom or slavery. This does not mean that each problem has only two facets but simply that public action can best be mobilized, a denominator most easily struck, when there are only two sides. The most common formula is the "for or against" statement. . . Often the individual is not on either side in a completely unqualified sense, but the heat of public debate and the necessity of mass action reduce the problem to its lowest common denominator, the simple dichotomy. Each pressure group tries to phrase the issue in a way that will marshal sentiment on its side. . . The final solution of the issue is often one that practically nobody actually desires but which represents the ultimate outcome in the struggle of conflicting pressure groups—a struggle in which the weapons of distortion, intimidation, censorship, misinformation, and irrelevancy play important parts. (Davis 1949, p. 359.)

Thus, Reding (1974) expresses this polarized view in a letter to the *Psychiatric News*:

> The rehabilitation of human warehouses, euphemistically labeled "state hospitals," is a hopeless task, thank God. Adding good psychiatrists to such institutions is like pouring good wine into a bad barrel. . . There is only one way to deal with state hospitals or, for that matter, with prisons: empty them, close them, then blow them up, because, as is well known, state legislators cannot tolerate empty buildings. Then only shall we psychiatrists be cornered into honoring our Hippocratic oath and our social obligations. Then only can we be expected to go help the local communities take care of their own human problems instead of storing them out of their sight and ours.

And Mendel (1974*a*), in a paper presented at a conference on the closing of State mental hospitals, concludes with this statement:

> Since the hospital as a form of treatment for the severely ill psychiatric patient is always expensive and inefficient, frequently antitherapeutic, and never the treatment of choice, it behooves us now to develop a strategy and time table for dismantling the mental hospital.

Dingman (1974) counters with these observations:

1. State mental hospitals ought never to have been established.
2. They do exist and we have encouraged dependence upon them.

[8] Additional selected references detailing the plight of deinstitutionalized mental patients in the community include: Allen (1974); American Federation of State, County, and Municipal Employees (1975); Anonymous (1975*b*); California State Employees' Association (1972); Chase (1973); Crane (1974); Davenport (1974); Lamb (1975); Malloy (1974); Reich (1973); Reich and Siegel (1973); Saltzman (1975); Sheppard (1976); Slovenko and Luby (1975); Trotter and Kuttner (1974).

3. Suitable facilities to which to transfer the dependence do not exist at this time.
4. CCMHC's [comprehensive community mental health centers] are inheriting many of the defects of state mental hospitals and, therefore, there is little point in planning to transfer functions to them.
5. Closings on any major scale are unthinkable.

DEPOLARIZATION: MODERATION OF VIEWS

It is really only in the very recent literature that substantial tempering of polarized stances begins to become noticeable. Although, of course, some earlier writers adopted moderate viewpoints, it is primarily in the literature of the mid-1970's that the compromising of extremes has become dominant. It is now increasingly recognized and acknowledged that earlier diatribes against mental hospitals might have been unfair simply in their failure to acknowledge that these facilities do not necessarily nor uniformly fit the grim picture of dehumanization described earlier. In addition to what may be characterized as humane care, many mental hospitals, in fact, offer innovative and experimental programs and some provide as complete a range of services as those found in community mental health centers (Horizon House Institute 1975*b*; Jones 1975; Kedward et al. 1974; Kramer and Taube 1973; Lando 1976; Rosenblatt and Mayer 1974; Schapire 1974; Stubblefield 1976*a*; Texas DMHMR 1976).

Now, instead of partisan statements seeking to denigrate all alternatives, a continuum of treatment alternatives is proposed. Now, statements that acknowledge frankly that the world of mental health services has a place for both institutional and community-based facilities are becoming popular, and there is a strong call for co-existence. Barnett (1975, pp. 274–275), speaking more globally of health services in general, states that there must be:

> . . . a variety of approaches in health delivery to meet the variety of responses in the population to be served. The question no longer is: "How can we humanize the system?" Rather, it is: "What is the best procedure for what kind of patient?" Once there is variety, informed choice becomes possible for the patient. We should not fall into the trap of prescribing a new monolithic system for the present, no matter how "humanized" the new system may appear. A monolithic system (i.e., one without variety and choices) cannot be a humanized system.

This view is clearly shared by many concerned specifically with mental health services. The Executive Committee of the American Psychiatric Association has released a position statement declaring the need to retain chronic care facilities (Anonymous 1974*b*):

> While we applaud the trend toward the growing adequacy of community resources and the concurrent reduction of the patient population in public mental hospitals, we now view with considerable concern the trend toward the phasing out of the capacity for providing long-term inpatient care and treatment for the mentally ill or disabled.

The APA statement cites as a major reason for this position that "pressure to discharge patients from the public mental hospital too often results in discharging patients without adequate planning, which in turn results in their living in substandard and dehumanizing circumstances." A Senate Select Committee of the California Legislature has sought to abandon earlier plans to phase out all State mental hospitals; it is now proposed that hospitals be integrated into local service delivery systems (State of California 1974).

De la Torre (1973) points out that "one should keep in mind that prevention of hospitalization is a means and that the prevention or amelioration of psychiatric illness is the real end." Nowhere is the newly emerging broad awareness of the need for a range of services including the mental hospital better expressed than in a paper presented by the British psychiatrist, John Wing (1975):

> The quality of life lived by the patient and his relatives is the final criterion by which services must be judged. A good hospital is better than a poor hostel or a poor family environment. A good family environment is better than a poor hospital or a poor hostel. The same may be said of day-time environments—open employment, enclaves in ordinary commercial business, rehabilitation or sheltered workshops, or protected day centers. Universal denunciation of any one type of setting is likely to be harmful since it is clearly not based on rational principles of assessment, treatment or care.[6]

Current writings on deinstitutionalization appear also to be considerably less emotional in tone than the earlier treatises. Now, some of the affect

[6] Selected additional references illustrating the emerging depolarization in viewpoint include: Mechanic (1975*b*); Ochberg (1975); Reich and Siegel (1975); Smith and Hart (1975).

has been tempered by practical experience. Whereas earlier statements were based on untested assumptions, and "oversimplifications served as the rocks upon which programs were sometimes hurriedly built" (Black 1974), today's viewpoints are grounded in a decade and more of reality (Goldman 1976). The deinstitutionalization movement now possesses a history, however brief (Anonymous 1976*d*), and many current positions are the result of experience.

III. SUMMARY OF ISSUES IN DEINSTITUTIONALIZATION

"But what kind of crusade is it to condemn sick and fearful people to shift for themselves in an often hostile world; to drag out, all too commonly, a hungry and derelict existence in a broken-down hotel if they are lucky; victimized, if they are not, by greedy operators of so-called halfway houses that are sad travesties on a fine concept? All without their even knowing the possibilities of new medical approaches to their illness—and all in the name of civil liberty."

—*New York Times* Editorial, April 8, 1975

Four recent articles appearing in journals have, in the view of this author, contributed greatly to summarizing the issues in deinstitutionalization and elucidating the critical nature of these issues. A very readable work by Kirk and Therrien (1975) examines issues in deinstitutionalization with a view toward exposing the "myths" which have surrounded the movement. A second article, by Greenblatt and Glazier (1975), serves further to amplify issues by focusing on some of the shortcomings in treatment at community-based facilities and on the general paucity of information available on which to base program plans. This reference is especially valuable for its clarity. A third article, by Becker and Schulberg (1976), appears in a nonpsychiatric medical journal. Entitled "Phasing Out State Hospitals—a Psychiatric Dilemma," its very placement in the coveted "Special Article" spot in the prestigious *New England Journal of Medicine* attests to the importance of the deinstitutionalization movement. This reference underscores the fact that the controversy concerning deinstitutionalization is no longer confined to the fraternity of mental health workers, nor even the popular press; even the greater medical community now feels constrained to review the issues. Finally, a sociological "case history" of a single State hospital (Fowlkes 1975) provides insights into the "structured resistance" to change in the world of mental health service delivery.

Together, these four articles give to the deinstitutionalization movement a well-deserved aura of importance and immediacy. They say, in no uncertain terms, that: (1) the issues in the deinstitutionalization movement are manifold, complex and serious; (2) the issues cannot be resolved by rhetoric; and (3) the time has come to evaluate these issues on a conceptual level in order to make them more comprehensible and more responsive to ameliorative efforts.

It is not the intention of the present study to rehash the issues in deinstitutionalization in detail. This has been done frequently, and often with great skill; and doing so here would merely be repetitious. It is, however, important to present some kind of taxonomy of these issues, short of detailed elaboration. This the present work attempts to do. Such an endeavor is by its very nature selective. So many complex problems have been cited, and there is so much overlap, that the mere selection, enumeration, and ordering of problems must reflect the biases of one who classifies them. Their specific ordering here results from the theoretical perspective employed, which will be detailed in the next section of this study.

The issues summarized here will be presented concisely. References to citations which amplify them will be provided. In addition to those issues which are dealt with directly in the literature, this study will discuss other issues, rarely labelled as such but apparent from a review of current writings —sometimes as much from a lack of systematic attention (as in the case of the problem of the views of institutionalized patients themselves toward deinstitutionalization) as from an examination of the elements involved.

A TAXONOMY OF THE ISSUES IN DEINSTITUTIONALIZATION

The issues in deinstitutionalization appear to fall into eight major groupings as follows: Issues related to the selection of patients[7] for community care; issues related to the treatment course of patients in the community; issues related to the quality of life of patients in the community; issues related to the greater community; financial and fiscal issues; legal and quasi-legal issues; informational issues; and additional issues resulting from the process of deinstitutionalization itself.

It cannot be too strongly emphasized that the issues presented here are separable only in theory. They are completely intertwined, and artificial separation of them at this time is made only for taxonomic purposes. Their ubiquitous interdependence should become apparent to the reader as he proceeds through the narrative supporting the catalogue of issues. In short, the system of care of the mentally ill in this society is institutionalized (in the sociological sense) and hence is characterized by an integration of its elements. Any specific element in the system is in many ways and by a variety of routes related to any other element, and a change affecting one element precipitates changes in all others. Thus, whether a specific problem in the deinstitutionalization movement—such as the limitations on physical mobility which many patients experience in the community—is classified under the second, third, fourth, or some other category mentioned above is a moot question. Theoretically, the problem belongs in all categories, and the specific assignment on paper is a matter of the author's discretion in judging where its placement seems to be most apt.

THE ISSUES EXAMINED

I. Issues related to the selection of patients for community care:

A. *Chronically ill patients*—According to Mechanic 1975*b*, p. 5), "one of the adverse consequences of the expansion of mental health concepts in the 1960's was the redirection of attention from the needs of the psychotic patient. . . Community mental health centers had diffuse missions and found it easier—and perhaps professionally more rewarding—to focus on assistance for those with less severe disorders." Kirk and Therrien (1975) write of their concern for "the fate of a specific group of patients: those who would have been or would be likely candidates for long-term hospitalization but who, because of the decline of the state mental hospital, are now residing elsewhere." The needs of chronically ill patients are often ignored in the community, partly because such patients tend to be viewed as what Kirk and Therrien (1975) call "an undesirable clientele," and partly because the facilities needed for treating them are lacking. Lamb (1975) asserts that most mental health professionals resist working with long-term patients in the community as the result of unwarranted bias.[8]

B. *Patients inadequately prepared for life in the community*—Place and Weiner (1974, p. 46) report from a followup study of patients released from Napa State Hospital in California, that "the most glaring deficiency of mental health services is the lack, if not total absence of programs designed to provide discharged patients with the practical skills needed to function in an ordinary community." Similarly, Anthony et al. (1972) conclude that although "inpatient treatment innovations improve the patients' in-hospital behavior . . . the research does not indicate that these approaches can singularly effect posthospital adjustment." Since long-term chronic care tends to "foster social and economic dependence" (Roth 1970, p. 61), it "creates norms and behaviors which reinforce the dependent role of the patient, [and] these behaviors are frequently at odds with those needed to survive successfully in the community" (Rutman 1976); re-entry into the community may thus prove extremely problematic for some former patients (Jansson 1975). Adjustment may require the establishment of "meaningful new social statuses" defining the position of former patients in the community (Sanders 1974). Stubblefield (1976*b*) refers to a related problem: placement of rural patients in urban aftercare settings as the result of "limited to nonexistent" resources in their home communities. Such "transplants" experience heightened psychological and social burdens in rehabilitation.

C. *Disadvantaged and minority groups*—Weclew

[7] "Patients" for purposes of this study are loosely defined as those individuals who are, have been, or might have been, but for the deinstitutionalization movement, on the rolls of long-term mental institutions, especially State hospitals.

[8] Numerous references deal with the plight of chronically ill patients in the community. Selected examples include: Becker and Schulberg (1976); Crane (1974); Falk and Murphy (1976); Hogarty (1971); Lamb (1976*a*); Reich (1973); Reich and Siegel (1973); Whittington (1969).

(1975) contends that community-based services tend to be irrelevant to the needs of Latino patients and that this results in their underutilization of such services. Mayo (1974) points out similar problems in the community treatment of blacks. Other studies deal with difficulties in providing relevant treatment to rural patients, to elderly patients (Anonymous 1976*f*; Becker and Schulberg 1976; Flashner, Engadela and Alderman 1974; Hicks 1976; Muskie 1974; Redick 1973), and to patients of low socioeconomic status. Myers and Bean (1968) assert that "adjustment in the community is most difficult for lower-class patients." A common denominator in these observations dealing with disadvantaged and minority groups appears to be that community treatment needs to be tuned in to the cultural needs of the patients which it serves. It must be more aggressive than hospital-based treatment: patients in the community must be attracted in such a way that they will voluntarily utilize the facilities.

II. Issues related to the treatment course of patients in the community:

A. *Inadequate range of treatment services*—The range of treatment services available to patients in the community must be expanded and elaborated (Rutman 1976). Kirk and Therrien (1975) indicate that there is a "lack of knowledge about what would constitute an effective and inexpensive treatment [for former mental patients] . . . The only partially effective treatments are the psychotropic drugs, but these are clearly only a first step." Rosenblatt (1975) proposes the formation of nontherapy-oriented custodial care facilities in the community. Roublin (1975), however, argues for more direct patient treatment which "is not even a part of some community mental health programs." Allen (1974), a former patient, writes:

> Regardless of what treatment programs exist in the community, they surely are not providing *enough* therapy. I myself see many, many people who, so far as I can tell, are untouched by anything that resembles treatment. . . I believe the majority of board and care residents live in an isolated, removed, seldom-changing, untouched world. There is a very real possibility that yesterday's back wards of State mental hospitals are becoming today's board and care homes.

B. *Fragmentation and lack of coordination in community treatment services*—Community-based mental health services are frequently lacking in centralized administration, and this results in fragmented responsibility. Relevant agencies do not have open lines of communication. Kirk and Therrien (1975) suggest that community-based services need to have "a single agency or person acting as sole agent or advocate for the patient or having primary responsibility for seeing that . . . [his] many needs are adequately met." The issues of fragmentation and lack of coordination are among the most widely and heatedly discussed in the literature. Selected references dealing with these issues include: Gittelman (1974); Grenny and Crandell (1973); Horizon House Institute (1975*b*); Rutman (1976); Zehr (1969).

C. *Inaccessibility of treatment services*—Community services may prove to be less accessible to mental patients than hospital-based services in a variety of ways—e.g., limited business hours at service facilities, or greater time, distance, and financial resources required to travel to such facilities. Feldman (1974) lists three components of accessibility: geographic, financial, and psychological. With respect to psychological accessibility, it is necessary that community care be aggressive; it cannot be assumed that because treatment facilities exist, patients will automatically utilize them (Davis, Dinitz and Pasamanick 1972). Discussions of accessibility issues are found in Feldman (1971), Mannino, Rooney, and Hassler (1970), and Mechanic (1975*a*).

D. *Questionable quality of care in community services*—The limited range of available services, the fragmentation of services, the inaccessibility of services—as well as the precipitate manner in which community service networks have sometimes come into being—combine in such a way as to raise serious doubts concerning whether patients are getting optimal treatment (Allen 1974; Hoshall and Friedman 1975). Special objections have been raised by some writers to what is considered disproportionately heavy reliance on psychoactive drugs—sometimes to the exclusion of other treatment modalities—in the community. See, for example, Crane (1974), and Scheff (1976).

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*Numerous references deal with the special needs of mental patients residing in rural areas. Selected examples include: Bentz, Edgerton and Hollister (1971); Brown and Taylor (1966); Buxton (1973); Cody (1973); Edgerton and Bentz (1969); Gertz (1974); Gertz, Meider and Pluckhan (1975); Greene and Mullen (1973); Guillozet (1975); Gurian (1971); Hollister (1973); Kraenzel and Macdonald (1971*a*); Kraenzel and Macdonald (1971*b*); Lee, Gianturco, and Eisdorfer (1974); Procter (1973); Taylor (1973); Torino (1975).

III. Issues related to the quality of life of patients in the community:

A. *Inadequate community support systems*—For all persons, "successful functioning depends on the material assistance and emotional support we receive from our fellows" (Mechanic 1975*a*). Such supports are frequently unavailable to mental patients residing in the community, often as the result of the very special psychological and interactional difficulties that characterize them. "Without well-organized and aggressive [community support] services . . . patients are often lost in the community and eventually end up in difficulty" (Mechanic 1975*b*). Accessibility is also a problem in community support systems. These systems are needed to assist noninstitutionalized patients in those areas of life where friendly intervention and a helping-hand are frequently needed—e.g., the development of friendship networks, the seeking out of employment opportunities, and the organization of leisure and social activities. Sometimes support systems are needed to assist patients in areas related to treatment—e.g., in setting up of appointments and transportation to therapy sessions.

B. *Residential facilities and living arrangements*—"The first obstacle faced by every state hospital system which wants to close down is what to do with the large number of patients currently hospitalized, some of them hospitalized for many years. Many of these patients have neither family who want them nor financial or social resources to secure adequate housing" (Kirk and Therrien 1975). Clearly, noninstitutionalized patients cannot always live "at home." Kramer (1970) outlines these underlying assumptions which are "central to the expectation that patients can be kept in their homes":

> (1) Patients have a home. (2) Patients have a family or other persons who are willing to assume responsibility for them and are well enough and financially able to provide the necessary care. (3) Patterns of organization and interpersonal relationships in the patient household are such as not to impede or prevent the recovery or rehabilitation. (4) The family has sufficient understanding of the patient's illness and expected behaviour so as to develop attitudes which assist rather than retard recovery and rehabilitation. (5) The patient's behaviour and his needs are such that his presence in the household does not produce undue hardships for the other members of the household and does not precipitate secondary attacks of disease and disability in the other members. (6) Appropriate medical, psychiatric, nursing, social work and related services are readily accessible to meet the changing needs of the patient and his family.

Although the various alternative living arrangements such as halfway houses, homes for the aged, boarding homes, nursing homes, residential hotels, etc., which have been designed for the housing of mental patients in the community, have often [in specific instances] been found adequate and even preferable to hospital residence, most reports indicate that on a widespread basis they usually have fallen short of the desired goal of providing a humane environment.[10]

IV. Issues related to the greater community:

A. *Community resistance and opposition to mentally ill individuals*—This is a much discussed issue in the literature. There appears to be consensus that society has difficulty in dealing with the presence of mental patients in their midst. Kirk and Therrien (1975), in discussing patients discharged from mental hospitals, summarize the position: "Former patients are not welcomed back into communities with open arms; instead they are often confronted by formal and informal attempts to exclude them from the community by using city ordinances, zoning codes, and police arrests." They conclude that "Residence 'in the community' can be just as disabling, frightening, dehumanizing, and isolating as living in the back wards of more formally structured institutions."[11]

B. *Effects on communities to whch patients are released*—In urban areas, services for deinstitutionalized mental patients tend to be concentrated in certain neighborhoods, and "a highly visible and significant new problem has evolved . . . in the selective concentration of a variety of service fa-

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[10] Numerous references deal with the problems of living arrangements and residential facilities within the community. Selected examples include: Bachrach (1975*b*); Brodsky (1968); Cumming (1975); Davis, Dinitz, and Pasamanick (1974); Deasy and Steele (1976); Edelson (1976); Heinemann, Yudin, and Perlmutter (1975); Kramer and Taube (1973); Lamb and Goertzel (1971); Mannino and Shore (1975); Miller (1970); Muskie (1974); Robbins and Robbins (1974); Schulberg, Becker, and McGrath (1976); Sheppard (1976); Thompson (1975).

[11] Numerous additional references deal with the issue of community resistance and opposition to mentally ill persons. Selected examples include: Anonymous (1976*g*); Aviram and Segal (1973); Farina et al. (1974); Greenblatt and Glazier (1975); Horizon House Institute (1975*b*); Lowinson and Langrod (1975); Ochberg (1974); Orndoff (1975); Piasecki (1975); Rutman (1976); Segal (1975); State of Michigan (1974); State of New York (1976).

cilities in certain neighborhoods, to a point of possible community saturation" (Wolpert 1975*b*). Some effects of this problem are the diminishing of real estate values and out-migration of the resident population. There are other kinds of problems in rural areas. Population sparsity creates problems in absorption of deviants. A special problem of increasing numerical significance in rural areas, not as yet reported in the published literature, is explained by R.D. Morrison (1976), who refers to the "tragic recruitment into the migrant labor stream of prematurely or inappropriately discharged mental patients who relapse under the strain of migrant existence and become expensive charges" of the Commonwealth of Virginia.

C. *Ecological impacts on economy of hospital community and on hospital staff*—The economic structure of communities in which large mental hospitals are located may be entirely dependent on the existence of the hospital. Dingman (1974) asserts that "dozens of towns in the United States owe their existence entirely or principally to a state hospital. In many dozens more localities, the state hospital has provided the largest single source of demand for the development of supply systems, educational systems, and so on. The ecological impact of a state hospital closing is unassessable—staggering—incredible in its proportions. The fact that we have no notion as to how to meet our obligations to these communities does not make the obligation go away." In addition, there is evidence that the closing of mental hosptials has adverse effects on the morale of staff (Greenblatt 1974; Ishiyama 1974; Khan and Kaplan 1974; Schultz, Lyons, and Nothnagel 1975; Weiner, Bird, and Associates 1973; Whittington 1969) who are concerned with their chances for alternative employment (American Federation of State, County and Municipal Employees 1973; Anonymous 1975*e*; Anonymous 1976*e*; California State Employees' Association 1972; Feldman 1974; Horizon House Institute 1975*b*; Weiner, Bird, and Associates 1973). The morale factor, in turn, may affect the quality of patient care provided during the period when the hospital is preparing to close.

D. *Effects on patient's family*—"Returning patients to their families," says Doll (1976) "is, of course, a logical step in the deinstitutionalization movement. And yet as progressive as that movement is, it may be causing serious crises in the lives of those families who are now responsible for the care and rehabilitation of relatives released from mental hospitals." Arthur (1973) claims that the "question of whether there are long-term subtle deleterious effects on other family members has yet to be resolved." A report by Doll (1976) indicates that even in the short-run, the patient's presence at home may put severe emotional and social strain on other family members, and he argues that if "family crises [are] severe enough, the trend toward community care may have to be reversed and permanently replaced by institutional care." Slovenko and Luby (1974) assert simply that "it is not to be forgotten that the family too is to have rights." [12]

V. Financial and fiscal issues:

Numerous references deal with the financial and fiscal problems associated with community care.[13] Opinion concerning the cost-benefits of community over hospital-based care is divided, but there seems to be consensus that the deinstitutionalization movement is encountering substantial fiscal problems. In fact, according to Kirk and Therrien (1975), the knowledge required to make accurate cost assessments is simply not available. They refer to "the transfer of major fiscal responsibility . . . from the mental health facilities to the public welfare enterprise," and conclude that "no one knows the magnitude of these hidden costs of community mental health or how they compare with the costs of hospitalization." Among such hidden costs are the "indirect costs incurred by other community agencies that are called upon to deal with the patients"—e.g., police, courts, emergency rooms, family agencies, etc. (Kirk and Therrien 1975). Arnhoff (1975) suggests that, after considering these intervening variables, the "actual cost-benefits of community treatment . . . are far less than its advocates proclaim."

VI. Legal and quasi-legal issues:

Ennis (1975, p. 83) writes (reprinted by permission of the publisher, Lexington Books, D. C. Heath and Co.):

> Courts have always been concerned to some extent with the legal rights of persons facing in-

[12] Other references dealing with the effects of deinstitutionalization on patients' families include: Arnhoff (1975); Creer and Wing (1974); Cumming (1975); Doll, Thompson, and Lefton (1976); Falk and Murphy (1976); Heinemann, Yudin, and Perlmutter (1975); Hill House (1975); Robbins and Robbins (1974); Strauss (1975).

[13] See, for example: Macht (1974); McClintock (1975); Murphy and Datel (1976); Peterson (1976); Sharfstein and Nafziger (1976); Sheehan and Atkinson (1974).

voluntary commitment to a state institution for the mentally ill or mentally retarded. But until very recently courts have refused to look behind institution doors. It is, literally, only in the past five years that courts have begun to consider the rights that patients retain inside such institutions once they are there lawfully. The rights that have become the focus of that examination include the following: the right to treatment; the right to refuse treatment; the right to protection from harm; the right to be paid for institution-maintaining labor; the right to be treated in the least restrictive setting and in the least restrictive and intrusive manner; the right to a free lawyer to resolve problems resulting from and problems separate from institutionalization; the right to a nonrenewable limitation on the permissible period of involuntary institutionalization; the right to decent living conditions—including the right to regular outdoor exercise, adequate clothing, and adequate medical care; the right to a public education regardless of the degree of mental handicap; and the right to meaningful notice—not just notice, of these and other rights.

With the deinstitutionalization movement, concern about these rights has followed patients as they have re-entered and/or taken up residence in the community. Legal and quasi-legal issues in deinstitutionalization are extremely complex and have increasingly been the subject of a number of excellent and informative treatises.[14] In addition, such issues increasingly are becoming the subject of concern in lay publications.[15] One major focus in this area, which has lately become the target of vigorous debate, is the matter of "dangerousness." Zitrin (1976) reports that records of discharged patients from the Bellevue Hospital catchment area show criminal arrest rates, including rates for violent offenses, that are higher than corresponding rates in the community. Langsley, Barter and Yarvis (1976) assert that "mental health professionals are not good predictors of dangerousness"; Dix (1976) concurs in this view. Perhaps in this particular problem lies a substantial portion of the explanation for the emotionalism and polarization surrounding the entire question of deinstitutionalization.

VII. Informational issues and accountability:

A. *Necessity for evaluation studies*—Effective and conclusive research has lagged in the deinstitutionalization movement. Even the extent to which community-based facilities and mental hospitals tend to serve the same—or different—patient populations is not yet known: Reports on this matter show conflicting results.[16] In order for realistic and effective program planning to take place, it is first essential to identify the population which is to be served and then to ascertain whether the target group(s) are being reached (Bachrach 1975*a*). It is also necessary to have ongoing evaluation studies to provide the feedback necessary for planning and implementing modifications in programs already in process (Glenn 1975; Goertzel 1976; Hargrove 1970; Matlins 1975; Schapire 1974; State of New York 1976; Yudin and Ring 1971; Zusman 1971; Zusman and Ross 1969).

B. *Difficulties in locating and following patients in the community*—Many of the followup studies already conducted have shown substantial percentages of released patients who could not be located in the community.[17] Thus, many followup studies are based on samples which are biased by the exclusion of patients who could not be contacted.[18] The inability to locate individuals for followup studies is, of course, a reflection of the inability to locate them for purposes of pursuing prescribed treatment courses.

C. *Inadequacy of existing followup studies*—The question of what actually happens to patients who leave mental hospitals and re-enter the community is largely unanswered. Although many followup studies with varying degrees of sophistication in

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[14] Selected references include: Anonymous (1976*c*); Bazelon (1976); Dix (1976); Ennis (1975); Flaschner (1975); Langsley and Barter (1975); Langsley, Barter and Yarvis (1976); McDonald (1974*a*); McGarry (1976); Monahan and Geis (1976); Redlich and Mollica (1976); Robitscher and Luce (1976); Sehdev (1976); Slovenko and Luby (1974); Stone (1974); Stone (1975*a*); Stone (1975*b*); Zitrin et al. (1976).

[15] See, for example: Anonymous (1976*a*); Kiernan (1976); Knight (1976); Smith (1975).

[16] See, for example: Aanes, Klaesy, and Wills (1975); Arthur Bolton Associates (1975); Bockoven and Solomon (1975); Dyck (1974); Kentsmith. Menninger and Coyne (1975).

[17] See, for example: Anonymous (1975*a*); Bristow, Harris and Henderson (1966); Horizon House Institute (1975*a*); Place and Weiner (1974); Wiggins (1970).

[18] Numerous references deal with the difficulties of tracking mental patients in the community. Selected examples include: Bachrach (1972*b*); Bachrach (1972*c*); Bachrach (1976*b*); Feldman (1974); Kedward et al. (1974); Kramer (1970).

design are reported in the literature,[19] their results are largely inconclusive in any broad sense. For the most part, these works have very limited replicability and generalizability (Bachrach 1976*a*). There is a need for more followup studies of mental patients after their release into the community (Kedward et al. 1974; Rosenblatt and Mayer 1974); and these studies should have comparability and generalizability in order that meaningful decisions regarding community-based care can be made. In short, "we need accurate, standardized information regarding our present systems of care in order to make just and rational decisions regarding future allocations of scarce mental health resources" (Greenblatt and Glazier 1975).

VIII. Additional issues resulting from the process of deinstitutionalization itself:

A. *Timing: precipitate implementation of new programs*—Deinstitutionalization has often proceeded with such rapidity that there has hardly been time to plan carefully for community-based programs with a view toward meeting special needs and overcoming special problems of target groups. Issues of acceptability and inaccessibility of services have often been overlooked in the haste of implementing new programs.[20]

B. *Inadequate attention to patients' desires*—A thought-provoking article by Mayer and Rosenblatt (1974) points out that "the opinions of mental patients traditionally have been ignored by mental health researchers, although they are most relevant if patient care is to be improved. A comparison of patient and staff opinion reveals that patients have a more positive view of the hospital, and disagree with staff in their conceptions of what makes patients 'get better'." Herjanic, Stewart and Hales (1968) caution that a successful community program must "be satisfactory to the patient." Although some investigators[21] approach or attest to the importance of this area of concern, the problem is distinguished more by oversight than by prominence in the literature.

C. *Problems related to providing adequate services in hospitals during phase-out*—This issue is summarized in a statement by Kram (1975): "It is unrealistic to expect a hospital to function at its best in the midst of funding cutbacks or after a decision has been made to close it." Staff morale and uncertainty about the future become matters of concern in this connection.

D. *Failure to establish liaison between hospitals and community-based facilities*—Inextricably tied up with the problem of inadequacy of followup procedures is a situation wherein deinstitutionalized individuals must sometimes fight their way through massive red tape in order to be treated in the community. A former patient makes this observation: "Sometimes it seems as if the mental health care system has become so complex that one needs a college degree just to be a patient" (Hoshall and Friedman 1975). This problem is closely related to the fragmentation of community services and to the failure to provide adequate community support systems as described above.

E. *Role-blurring*—Mental hospitals have a notable advantage over more loosely structured community-based facilities in that, at the former, the social structure is more clearly defined. There is an easier understanding of statuses and roles—of who does what for or to whom and in what contexts. Some may object to the actual normative content of the statuses in hospitals, but at least the definitions are there and are relatively clear. When patient care is transferred out to the community, traditional definitions no longer seem to work, and *anomie*—a "social condition characterized by a general breakdown, or absence of norms governing group and individual behavior" (Hoult 1969, p. 21)—results. Thus, Sanders (1974), who writes that "it is quite obvious that the chronic mental patient does establish and generally maintains a stabilizing role in the hospital, which is something he has not been able to accomplish in the community, even on a minimal level," connects such role-blurring with high recidivism. Not only does role-blurring occur among patients, but it also occurs among staff members in the community. Ochberg (1976) attributes this situation to the existence in the community of "curious and creative people discovering ways to use their skills in new settings" and anticipates that the confusion

[19] See, for example: Anthony et al. (1972); Davis, Dinitz, and Pasamanick (1972); Davis, Dinitz, and Pasamanick (1974); DiScipio (1973); Fakhruddin, Manjooran, and Nair (1972); Franklin, Kittredge, and Thrasher (1975); Grenny and Crandell (1973); Herjanic, Stewart, and Hales (1968); Lafave, Stewart, and Grunberg (1968); Lamb and Goertzel (1972*b*); Martin and Sterne (1975); McClintock (1975); Michaux et al. (1969); Myers and Bean (1968); Place and Weiner (1974); Singer and Cobb (1975); Wiggins (1970).

[20] Selected references dealing with the problem of timing include: Becker and Schulberg (1976); Easton (1974); Glenn (1975); Jones (1975); Robbins and Robbins (1974).

[21] See, for example: Mechanic (1968, p. 89); Sanders (1972); Wanberg, Horn, and Fairchild (1974).

will eventually "unravel." Pattison et al. (1976) report that the Orange County (California) Department of Mental Health has found it expedient to develop a code of ethics for employees as the result of "problems of role definition and interdisciplinary collaboration" in the development of a community program. Additional references amplifying problems of role-blurring include Glass (1975) and Miller (1974).

F. Disenchantment with the deinstitutionalization movement: resistance to further change—As noted by Becker and Schulberg (1976):

> The vast majority of patients currently cared for in state hospitals could be adequately treated in the community if a comprehensive spectrum of psychiatric services and residential alternatives were established. The failure to establish this network of community services before the discharge of thousands of patients has discredited the deinstitutionalization programs in many states.

This issue is closely related to the issue of timing discussed above (Easton 1974). In addition, some writers feel that the deinstitutionalization movement has been remiss in failing to define its boundaries clearly. In seeking to assist in a variety of social, as well as psychiatric, problems—in attempting to fill the lacunae perceived in mental hospital treatment—the movement has sought, according to Lasch (1976) to "provide a universal cure for the miseries of existence." This has at times proved to be problematical, though not altogether without positive value in program implementation.[22]

Synthesis

Each of the issues examined here may be viewed as an intervening variable in the success of the deinstitutionalization movement. The aggregate effect of these complex and interrelated issues has been to create a situation wherein the movement has, since its inception, confronted obstacles every step of the way. It is almost as if it has been on a collision course, encountering roadblocks at every turn and creating new barriers in the process of trying to remove old ones.

One of the ironies that strikes the student of deinstitutionalization is that the issues discussed here are not necessarily newly revealed. One can only speculate as to whether the problems which the movement faces today are inevitable consequences of social change, or whether some of these problems might have been avoided or mitigated had more notice been taken when they were first mentioned in the literature. Kramer et al. (1956), for example, wrote as long as 20 years ago:

> So that we may really be able to assess what a course of hospitalization has accomplished, we need answers to questions such as the following: of patients who have been returned to the community, how many relapse and how soon? How are relapse rates related to diagnosis, sex, age on admission, length of hospitalization, therapy? What social and environmental factors encountered by discharged patients are related to relapse or successful readjustment? Accurate follow-up data on discharged mental patients can serve as the basis for "discharge prediction" techniques, weighting significant factors in the patient's life history, diagnosis, clinical course in hospital, degree of improvement, and expected family and community environment. Better understanding of relapse factors would greatly aid the development of rehabilitation programs for patients while they are still in the hospital and later when they have returned to the community.

Thus, it is not as if some of the questions that needed to be asked before the deinstitutionalization movement took on momentum were never raised. They were raised; but, in practice, they were not acknowledged. The movement went forward on its own momentum, too often impervious to attempts to steer it onto a course consistent with clinically derived principles and theoretically derived expectations.

[22] See, for example: Cumming (1974); Dinitz and Beran (1971); Rosenfeld (1976); Wagenfeld (1972).

IV. A FUNCTIONALIST PERSPECTIVE

"Because of the interdependence of the components of society, change at any one point is likely to precipitate changes elsewhere. These changes may come unheralded, unpredicted, and frequently from the viewpoint of many groups, unwanted."

—Ely Chinoy, 1954

The functionalist approach in the behavioral sciences consists of a series of basic concepts which are interrelated within a theoretical framework fundamentally oriented toward the understanding of social change. In the present section of this study, some of these concepts will be explained and will then be applied to the issues described in the previous section. The importance of social change within the functionalist framework will then be emphasized as the basis for further examination of deinstitutionalization issues.

BASIC CONCEPTS IN THE FUNCTIONALIST APPROACH

The central concept in functional analysis is the *function,* which is defined in terms of contributions to the "fulfillment of one or more social needs of a social system or subsystem" (Johnson 1960, p. 63). In brief, each form or element of a social system—whether a cultural item, pattern, status, norm or value—is identifiable in terms of the functions it serves for society, or, in other words, in terms of the social needs which it fulfills. Note that a *function* is to be differentiated from a *purpose,* and that this distinction is an important one. Although the two may be, and often in particular instances are, identical, a purpose is to be regarded as something subjective, a charge; a function is to be regarded, by contrast, as an objective phenomenon. In very simplified terms, a purpose is that which a social form is intended to do, and a function is that which a social form actually does. To illustrate, the purpose of opening a crisis center may be to provide ready intervention in emergency situations; the functions of the crisis center may include, in addition to this purpose, other functions, such as providing employment for telephone operators and providing outlets for community service organizations. In fact, these latter functions may persist in keeping the crisis center open even if the original purpose of emergency intervention is no longer being fulfilled.

Functions are to be understood as positive phenomena, in that they fulfill societal goals or objectives and thus contribute to the survival of society's institutions. Sometimes, social forms are, however, negative in consequence and actually inhibit the realization of societal goals. In such cases, the social forms are said to be dysfunctional. The distinction between function and dysfunction is described in this way by Merton (1957, p. 51): *"Functions* are those observed consequences which make for the adaptation or adjustment of a given system; and *dysfunctions,* those observed consequences which lessen the adaptation or adjustment of the system." Thus, for example, operators' personal use of crisis center telephone lines to the extent of interference with the receipt of emergency calls becomes a dysfunctional element in the enterprise. A given social form may be both functional and dysfunctional, depending on the point of view of particular social subsystems. In our simplified example, the telephone operators may realize fulfillment of personal goals, while the organizational goals of the center are being inhibited by the influx of non-business calls.

Functions may also be characterized according to whether they are manifest or latent. *Manifest functions* are, in general, those that are "intended and recognized by the participants in the system" (Merton 1957, p. 51). Contrariwise, *latent functions* are unintended, and, for purposes of the present study,

may be understood as *unanticipated consequences* of given social forms. Latent functions are not necessarily dysfunctional, although they may be. The illustration of the inaccessible telephone lines is clearly both unanticipated and dysfunctional. On the other hand, the provision of employment opportunities for telephone operators, while a latent function, is positive and hence not dysfunctional. The importance of the distinction between manifest and latent functions is explained by Chinoy (1954, pp. 39–40):

> It is essential in examining the functions of social institutions to distinguish between the purposes or reasons which are conventionally given for their existence and the objective consequences which flow from them. Purpose and result need not and in most cases probably do not completely coincide. . . A distinction therefore must be made between manifest and latent functions.

An additional concept in the functionalist approach is that of the *functional alternative*. This is explained by Merton (1957, pp. 33–34):

> . . . *just as the same item may have multiple functions, so may the same function be diversely fulfilled by alternative items.* Functional needs are here taken to be permissive, rather than determinant, of specific social structures. Or, in other words, there is a range of variation in the structures which fulfill the functions in question.

It now becomes increasingly clear, in the context of the functionalist perspective, that *the deinstitutionalization movement in the United States represents a search for functional alternatives to the mental hospital.*

APPLICATION OF CONCEPTS: THE FUNCTIONS OF ASYLUM AND CUSTODY

This characterization of the deinstitutionalization movement as a quest for functional alternatives demands that the functions—manifest and latent—of the mental hospital be made explicit. An attempt to do so, at least partially, was made in a largely overlooked article by a psychiatrist, Robert M. Edwalds, over a decade ago (1964). Edwalds held that "the primary social functions of the state mental hospital are not the same as the publicly proclaimed purposes and goals of these institutions." He wrote:

> Primary functions demanded of the state mental hospital have included (A) public safety and the removal from society of individuals exhibiting certain kinds of socially disruptive behavior; (B) custodial care for persons who, by reason of mental disorder, cannot care for themselves or be cared for elsewhere. . . Treatment and rehabilitation of the mentally ill has always been, at best, a secondary function of the state mental hospital. For many years it was not considered part of the function of the state hospital at all. Today treatment and rehabilitation are usually officially regarded as the primary functions of the state mental hospital, leading to a remarkable amount of self-deception and confusion on the part of society and the personnel working in these hospitals.

Edwalds saw the very use of the term hospital to refer to these mental institutions as misleading and productive of naive misunderstanding of the "true" functions.

What Edwalds was saying, translated into functionalist terms, is that, although the stated goal of the mental hospital may be treatment and rehabilitation of the mentally ill, this is at best only a limited function. Instead, the major functions of the mental hospital are, in reality, custodial in nature. These custodial functions of mental institutions are grounded in the social history of this Nation (Dain 1971; Jarcho 1976; Rutman 1976).

The importance of Edwalds' position cannot be overemphasized! If his characterization is accurate, a giant step toward understanding the issues inherent in deinstitutionalization was taken over 10 years ago, when the movement was young. To the extent that Edwalds' theory has validity, it may be hypothesized that *many of the problems confronting the deinstitutionalization movement result from the failure to provide functional alternatives for some of the basic functions served by the mental hospital.* The logical conclusion that follows from a functionalist point of view is that *mental hospitals must not and cannot be eliminated until alternatives for the functions of asylum and custodial care have been provided.*

The early literature on deinstitutionalization, which reflects the mood underlying program planning in the 1960's, largely ignored or discounted these custodial functions of mental hospitals. Instead, the focus was on providing *treatment* (not custodial care or asylum) in the community. But, as it turns out, Edwalds was prophetic. His name is, for the most part, absent from bibliographies and literature reviews.[23] Yet, recognition of the

[23] A notable exception is Dingman (1974), who utilizes the Edwalds article as the basis for much of a cogent argument favoring the retention and meaningful modification of the State hospital.

functions of asylum and custody has become more and more prevalent in the literature of the mid-1970's. Thus, Slovenko and Luby (1974) write:

> The medical model terminology has been misleading. When we use the term "hospital," we naturally think of treatment. Hospitalization without treatment is an absurdity. . . If, however, we understand by the term "hospitalization" nothing more nor less than asylum (as the mental hospital at one time was called), a place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense as meaning "handling of" or "how we treat one another." [24]

Fowlkes' article, entitled "Business as Usual—at the State Mental Hospital," (1975) —one of four recent articles cited earlier as contributing substantially to elucidating the issues in deinstitutionalization—is entirely devoted to an examination of those forces which serve to resist innovations at State mental hospitals and thus to preserve them as custodial institutions. Fowlkes, in effect, perceives a kind of conflict of interest in which institutionalized (in the sociological sense) aspects of the mental hospital are functional for some societal groups (hospital administrators and staff, patients' families, vested economic interests, etc.), but dysfunctional for others (patients).

If corroboration from modern experts is to be regarded as a measure of the validity of Edwalds' theory, one can only conclude that he was indeed on the right track at the wrong time.

APPLICATION OF CONCEPTS: ADDITIONAL FUNCTIONS

An attempt to isolate some of the functions of mental hospitals as identified in the literature yields the following listing:

- Providing long-term care for chronically disturbed individuals (Dingman 1974; Stewart 1975)
- Providing respite from mounting pressures for the patient (Dingman 1974; Stewart 1975)
- Removing the patient from "his usual interpersonal environment which may operate to perpetuate sick behavior" (Lewis 1973)
- Protecting the patient from "undue pressure" or exploitation by others (Dingman 1974)
- Providing a residential environment for the mentally ill (Fowlkes 1975)
- Providing constant and continuous monitoring and review of the patient's course of illness (Lewis 1973)
- Providing a social structure within which the role of the mentally ill individual is clearly defined (Rosenhan 1973; Sanders 1974)
- Providing the mentally ill individual with an alternative to due process of law (Polak and Jones 1973)
- Providing a place for escape for the patient from the society in which his behavior is "friction producing" (Polak and Jones 1973)
- Providing the means by which society can segregate its deviants (Polak and Jones 1973)
- Relieving the patient's family and community from disruptive social interaction (Fowlkes 1975; Aviram and Segal 1973; Doll 1976; Doll, Thompson, and Lefton 1976); "absorbing the strains of sickness" (Susser 1964)
- Protecting society from the acts of dangerous individuals (Dingman 1974; Hanson and Babigian 1974)
- Supplying the least expensive patient care for the mentally ill "on a short-run, annual budget basis" (Fowlkes 1975)
- Providing the economic base of and employment for a community or a portion of a community (Fowlkes 1975; Dingman 1974; Weiner and Bird 1973; Keenan 1974; Schulberg, Becker, and McGrath 1976)
- Providing job security and other job perquisites for numbers of employed persons (Fowlkes 1975; Ishiyama 1974; Weiner and Bird 1973; Schultz, Lyons, and Nothnagel 1975; Dingman 1974; Keenan 1974)
- Providing a tax base for local communities (Schapire 1974)
- Providing for mental health professionals in the community a "siphon[ing] off [of] the least affluent and least attractive of the mentally disturbed, whom they would prefer not to serve anyway" (Fowlkes 1975)
- Creating an "illusion that all local mental health needs are being met, thus eliminating

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[24] Selected additional references expressing the need to recognize the functions of asylum and custody at mental hospitals include: Bewley et al. (1975); Clausen and Huffine (1975); Chu and Trotter (1974); Cumming (1974); Dingman (1974); Finzen (1974); Lieberman and Gardner (1976); Rosenblatt (1974); Rosenblatt (1975); Rutman (1976); Saper (1975); Stone (1975a); Stotsky (1968).

the need for . . . local planning and spending for mental health care" (Fowlkes 1975)

- Providing a place for research on mental illness and training of mental health professionals (Dingman 1974; Stewart 1975)

This listing is limited to those functions of mental hospitals explicitly stated as such in the literature. Were it to be expanded by the inclusion of such functions as are also implicit in the literature, it would be even longer. But, even as it stands, it is sufficient to support an important observation. The issues in deinstitutionalization raised in the last section of this study fall into two major groupings vis-à-vis mental hospital functions. Either: (1) the issue has at least one referent among the functions listed, or (2) the issue has come into being as an unanticipated consequence—i.e., a latent function—of the deinstitutionalization movement. With respect to the former grouping, it is apparent that efforts to reduce the stature of, or eliminate, mental hospitals have too often failed to stress the necessity for alternatives to the custodial and other functions of mental hospitals. It is inevitable that any movement which so ignores the institutional makeup of society will encounter severe opposition.

With respect to the latter grouping of issues—those which emerge as products of the movement itself—it is apparent that the deinstitutionalization effort in process has not been viewed by its champions with sufficient detachment to permit program planners to recognize problems and introduce necessary modifications. Deinstitutionalization has left in its wake dysfunctional elements which result directly from rapid, and sometimes heedless, implementation of the movement.

In short, the ideological basis for deinstitutionalization is one which encourages rapid social change in an institution (in the sociological sense) which is woven into the fabric of American life. The semanticist, Hayakawa (1949, p. 276), explains the conservatism which such a threat engenders in his statement that "social institutions tend to change slowly—and, most importantly—they tend to continue to exist long after the necessity for their continued existence has disappeared, and sometimes even when their continued existence becomes a nuisance and a danger."

Part of the reaction against deinstitutionalization has resulted from society's resistance to what Coser (1975) calls the "threat of territorial invasion." Coser's argument (which deals with social change in other areas of American life) holds that geographical displacement typically constitutes enough of a threat to the existing social order to mobilize conservative antichange forces. Unless geographical displacement is "patterned in such a way that it will not interfere with the existing pattern of role relationships," it can become an intolerable threat to society. The role-blurring issue in deinstitutionalization provides evidence that geographical displacement in this instance has in fact interfered with role relationships and that part of the resistance to the movement may be understood in this way.

To recapitulate, the absence of acceptable functional alternatives for the functions served by mental hospitals, coupled with attempts to displace the territorial and other claims of the institutionalized system of mental health care—all occurring with great speed—have produced serious problems in implementing the goals of the deinstitutionalization movement.

A final word remains to be said regarding the functionalist approach. If there are gaps in the interpretation of deinstitutionalization that it affords, that is no surprise. It is not the intent of this study to suggest that the functionalist approach is *the* legitimate avenue to understanding deinstitutionalization. It is simply *an* approach, one which permits systematic ordering of the data, impressions, and judgments about deinstitutionalization that are found in the literature. Other theoretical frameworks will also be useful to this end, to the extent that they help to make sense of the elements in the process of deinstitutionalization and to unify seemingly discrete bits of material. In fact, other approaches should be viewed as potentially complementary to the functionalist perspective—as helping to enhance the understanding of elements that still appear to be at loose ends.

V. DISCUSSION

"Nowhere is the discrepancy between public and private morality, between verbal pronouncements and actual behavior, more apparent than in the field of psychiatric aftercare. The literature is replete with descriptions of demonstration projects, state-wide programs, bold innovations, and triumphs of interagency collaboration. Yet, an objective observer can quickly conclude, if he reviews the typical post-hospital experience of psychiatric patients, that aftercare services in reality do not exist for the vast majority of persons leaving state and local mental hospitals."

—H. G. Whittington, 1969

Has deinstitutionalization really, thus far, resulted in the exchange of one set of ills for another? Have the dysfunctional elements of institutional care merely been transferred to the community, so that, in the words of Slovenko and Luby (1975), "mental patients are going from the frying pan into the fire" and that "neglect in the community dwarfs neglect in hospitals"? If one proceeds from the assumption that the basic goal of the deinstitutionalization movement is the elimination of dehumanization in the treatment of the mentally ill,[25] one must acknowledge that, on the basis of the existing literature, community-based programs have not been immune to dehumanizing forces.[26] While the position taken by Slovenko and Luby may be an exaggerated or polarized statement, it does now seem clear that the deinstitutionalization movement has not had unqualified success in its humanizing mission. Like other movements of social reform, it has produced a series of largely unanticipated consequences (latent functions) of a dysfunctional nature; like other efforts at institutional change, it has brought into play the forces of resistance which have themslves at times been dysfunctional.

But this by no means necessarily indicates that the movement is a failure. It does, instead, mean that the time has come to face the issues squarely, so that the movement can achieve its promise. For example, it may now be understood—and potentially acted upon—that the issue of selecting patients for community care is closely related to the functional confusion described by Edwalds. Selection of a patient population or target group follows from an agency's understanding of its *raison d'être*. But if it is unclear what functions are to be transferred from the mental hospital to the community, it must also be unclear which patients should be served in the process. The deinstitutionalization movement may eschew the functions of

[25] Orndoff (1975, p. 222) adopts this assumption emphatically: "Institutionalization is a dehumanizing process where the patient's individuality is lost, his self-concept greatly lowered, and in many cases, his ability to make even the simplest life decisions seriously impaired. With this in mind, the goal of any community residential program must be to reverse the process."

[26] Perhaps an exercise utilizing the concepts of the sociologist Jan Howard (1975, pp. 60–66) can assist the reader in assessing the presence of dehumanization either in general or in specific instances where deinstitutionalization programs have been implemented. Howard isolates and describes 11 different referents of the concept dehumanization. The referent characterized as "thinging," the reduction of human beings to things, must certainly be viewed as part of the horror-story quality of life in many mental hospitals, as must another referent, "dehumanization by degradation." In general, deinstitutionalization efforts have succeeded only in partially eliminating these dimensions of dehumanization. On the other hand, in some instances where the rapid disgorgement of patients into communities without adequate provision for alternate care has taken place, other dimensions of dehumanization have been brought into play—for example, the experiencing of isolation and abandonment, and the production of groups of patients without options.

custody and asylum; but it must still acknowledge that these have been functions of the mental hospital, the need for which will not simply disappear with the dismantling of custodial facilities. With this recognition can come modified planning and action.

A major shortcoming of the deinstitutionalization movement, one which has clouded the issues and confounded investigative efforts, has been the tendency of persons connected with selected community programs to reason inductively that the entire movement is "working," when obviously this is not always the case, thus deflecting attention from the issues which must be resolved. A number of experimental community treatment models which report success are described in the literature,[37] and some of these are exceedingly innovative. However, persons encouraging the diffusion of specific treatment models frequently fail to comprehend the dimensions of the deinstitutionalization problem and the fact that their programs care for only a small portion of deinstitutionalized individuals. They frequently, in addition, fail to take into account that: (1) the resources—both personnel and financial—of their own communities may not be available to other communities; and (2) their specific programs may not be compatible with the culture bases in other communities. Too often, these programs preselect patients to fit in with criteria set by experimental design, and their supporters sometimes forget that these selected patients are not representative of *all* mentally ill people.

There have certainly been commendable community programs, and the importance of these is not to be minimized either in humane or experimental terms. But, at the present time, such isolated programs can only be perceived as bandaids. We must not delude ourselves into thinking that any one or a combination of such programs provides comprehensive answers to the massive problems of the deinstitutionalization movement. Although proponents of specific localized problems may be certain that one or another selected approach is "the answer," on a more general level it may well be asked, "What is the question?" In functionalist terms the question becomes one of identifying the appropriate functions of mental hospitals and the providing of functional alternatives in the community on a widespread—not just local—basis.

[37] Selected examples from among numerous reports include: Birley (1974); Brook et al. (1976); Claghorn and Kinross-Wright (1971); Driemen and Minard (1971); Elpers (1975); Guillozet (1975); Hofstatter et al. (1972); Kresky, Maeda, and Rothwell (1976); Lafave, Stewart and Grunberg (1968); Langsley, Barter and Yarvis (1976); Lanter (1976); Lowinson and Langrod (1975); Marx, Test, and Stein (1975); Mosher, Menn, and Matthews (1975); Polak and Kirby (1976); St. Clair (1975); Sanders (1972); Smith (1974); Stein, Test and Marx (1975); Test and Stein (1976); and Walter (1976).

VI. CONCLUSIONS

"That reform movements often create more problems than they solve has been noted, and the task of each succeeding generation is to correct the excesses of the last. . . There comes a time when reformist zeal must be matched against available data, and while the humanistic goals may persist the paths to them must be modified. This clearly is overdue for the field of mental health."

—Franklyn N. Arnhoff, 1975

"Fundamentally, the need that must be faced is the establishment of programs to meet the needs of people whether they are in institutions or in the community."

—Ralph Slovenko and Elliot D. Luby, 1975

The basic conclusions of this study are simple, and, it seems, inescapable. The deinstitutionalization movement—a movement intended to counteract the effects of dehumanization in mental health care—can best fulfill its promise if certain conditions are met. Individual mental hospitals are most effectively superseded, in accord with the aims of the deinstitutionalization movement, when: (1) there is a thorough understanding of the functions which they serve in American life; (2) consensus is reached as to which of these functions should be continued or discontinued, or which new functions should be added; (3) effective alternatives are established in community settings for the accepted functions; and (4) sufficient time is allowed for the systematic and orderly implementation of new programs and transfer of functions.

In one important respect the deinstitutionalization movement has come a long way. The era of polarization seems to be passing, and, finally, the voices of moderation are being heard. This sets the stage for more realistic planning. However, there still remain some very serious problems with which to contend. Although it is increasingly recognized that there must be a range of treatment alternatives including a variety of hospital- and community-based choices, there is little in the way of consensus regarding what *kinds* of service facilities can best fulfill what *kinds* of functions. Some choices must be made. Mental health service delivery agencies, particularly those which might appear to be less traditional and more innovative, have what Franklin and Kittredge (1975) call serious problems of legitimacy and boundaries. Legitimacy involves the "defining of a domain, a set of tasks or activities over which the organization claims jurisdiction." Whereas organizations whose services can easily be measured by accepted objective criteria have relatively less difficulty in establishing boundaries, it is extremely difficult to define boundaries for what these writers call "people-changing organizations." One reason is that there is considerable overlap in the jurisdictional claims among such agencies. The "boundary busting" nature of community mental health—its tendency to blur the boundaries of other agencies—is the subject of timely and thought-provoking discussions by Dinitz and Beran (1971) and Wagenfeld (1972).

If the deinstitutionalization movement is to proceed more effectively, it would seem that a first step to take is to define precisely, in the light of accumulated experience, what are the target groups for the movement. Precisely which patients are to be deinstitutionalized? What patients do we mean when we talk about providing community care? Do we mean all persons in mental hospitals, or do we mean only those, who by virtue of specific demographic or diagnostic characteristics they possess, may be assigned to some localized experimental

program? Do we mean patients who are hospitalized primarily for lack of other places to go—i.e., inappropriate hospitalizations?[28] Or do we mean only those patients who might be considered "good risks" for rehabilitation via the community route?

Lest this study appear to place undue emphasis on the negative aspects of deinstitutionalization, let it be made clear that the aim of this work is supportive in nature. In fact, this study may be regarded as an endorsement of the major goal of deinstitutionalization. Were this not the case, there would be no need for such a study. Focusing on dysfunctional elements of the movement is not an indictment but rather a necessary step in bringing to the surface those factors which have inhibited the movement's success. The final conclusion, of course, is that the deinstitutionalization movement can best proceed on its humanizing mission if it avoids territorial arguments: it is not necessary, and probably not desirable at this time, to expunge the mental hospital in order to achieve the goal of deinstitutionalization. It is certainly unwise to attempt to do so in haste. Community planners need to understand that hospitalization "does not, as some have suggested, signify the failure of alternative methods of care" (Adams 1975). There is a need to re-assess the functions which are known to be served by mental hospitals and to determine, without prejudice, those which are not likely to be fulfilled in community settings.

Mental hospitals that survive the deinstitutionalization movement can themselves aid in the humanizing effort. These hospitals will have the potential for elevating patient treatment to a primary function; the functions of asylum and custody do not preclude this. In addition to the brief hospitalization trend cited earlier, which can be implemented in mental hospital settings, other innovative programs can be encouraged. Day care, or partial care, which "apparently avoids the regressive features associated with 'total institutionalization'" (Herz et al. 1971)[29] is one such kind of program. Hospital-based outpatient care and outreach programs are others (Stubblefield 1976a; Texas DMHMR 1976). The siting of such programs at mental hospitals can in fact aid in overcoming the issue of fragmented care, especially if transportation for patients is facilitated. Along these lines, Johnson et al. (1975) advocate the "mini-mental health center," a program which provides both inpatient and outpatient care on a single hospital ward, thus allowing for comprehensive treatment by the same treatment team. These authors point out that the traditional mental health center can provide *continual care,* but their program has a capability for real *continuity of care,* which is not the same thing.[30]

Still other steps can be taken to make the movement more responsive to the needs of patients. Certainly one area where change is essential is in the setting and monitoring of standards for residential facilities. It is important to remember, in the words of Crane (1974), that "hospital substitutes, like halfway houses, day care centers, and nursing homes, can cope with a limited number of patients. The quality of their services can only deteriorate when the demand becomes excessive." Care must be taken to assure that such facilities are not overloaded or oversold.[31]

Another avenue for the enhancement of the goals of deinstitutionalization is the local screening of patients before their admission to mental hospitals. Screening programs can assist in the determination of which individuals definitely require custodial care and which can best be treated outside of institutions (Feldman 1974). Protests of partisans notwithstanding, screening can also assist in determining whether there exist patients for whom community-based care is *not* the treatment of choice and for whom hospitalization might really be the desired alternative. Finally, in addition to pre-admission screening for assignment or nonassignment to mental hospitals, there should be screening for the variety of care-giving agencies within the community as well. The screening program should thus take reponsibility for assignment of patients to residential facilities as well as treatment services.

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[28] The literature contains a number of studies dealing with inappropriate placement of patients in mental hospitals. Selected references include: Arthur Bolton Associates (1974); Arthur Bolton Associates (1975); Lund (1976); Sheehan and Craft (1975); Fottrell and Majumder (1975); Washburn, Vannicelli and Scheff (1976).

[29] Also see: LaCommare (1975); Lamb (1976*b*); McNabola (1975); Michaux et al. (1973*a*).

[30] Also see: Fox and Potter (1973); Hott (1971).

[31] A variety of references deal with the place of halfway houses and other residential facilities in the deinstitutionalization movement. Selected references include: Anonymous (1976*f*); Atkinson (1975); Cannon (1975*a*); Cannon (1975*b*); Edelson (1976); Horizon House Institute (1974); Lamb (1976*a*); Orndoff (1975); Ozarin and Witkin (1975).

Just as pre-admission screening may serve to minimize dehumanization, so should an effort be made to enhance the role of pre-release planning at mental hospitals. Many patients must be trained for life on the outside, and this represents a major opportunity for innovativeness and originality in the hospital setting. Pre-release planning must include, at a minimum, an effective referral mechanism. Zolik, Lantz, and Sommers (1968) have shown that patients released without referral are more frequently and more readily rehospitalized than those who have been given referrals. Pre-release planning must also include plans for the followup of patients in the community. Such plans must be prospective and must precede the patient's release. It is simply too difficult to track a patient retrospectively. Liaison personnel, who work between hospital and community-based facilities, are essential for followup.

It is important that the territoriality exhibited by competing community-based treatment and service agencies be neutralized by cooperative effort. It is possible to develop community-wide mental health plans which endeavor to implement the aims of competing organizations and to express the consensus of all participating units (Bachrach 1974). Such cooperative planning is to be strongly encouraged: it provides specific agencies with the knowledge that their views count and their contributions are valued. J. Howard (1975) provides a theoretical framework which may be used to view the fragmentation of community services in mental health. She presents four models of interaction between professionals and patients. In the 1:1 model a single professional provider relates to a single consumer. The 1:*n* model typifies one provider relating to more than one consumer, the *n*:1 model depicts a relationship between more than one provider and one consumer, and the *n*:*n* model contains both multiple providers and multiple consumers. Fragmentation, which is absent from the 1:1 model, is most pronounced in the *n*:*n* model. Deinstitutionalization has frequently resulted in a variety of service relationships with multiple producers and/or consumers and especially those of the *n*:*n* type. While this is not an "inherently depersonalizing" service model, Howard does suggest that it may present the most obstacles to humanized care.

Finally, not enough can be said about the importance of improved information systems in implementing the goal of the deinstitutionalization movement. It is essential that we know who is being treated where, with what success, and for what reasons. Unless a mental health plan can check itself and modify itself in process, its efforts run a huge risk of veering off-course and producing dysfunctional patterns which become increasingly difficult to reverse. The only way to assure that specific programs connected with deinstitutionalization efforts do not autonomously take on questionable latent functions is by effective monitoring and continuing assessment of their relevance through process and outcome evaluation. We can only know whether community mental health care "works" if we have the data to substantiate our premises. A quotation by Matlins (1975) is apposite:

> The basic function of planning and the research activities that take place as part of the planning process is to improve the quality of decisions made over time. The most striking characteristic of many planning systems is their failure to impact on the decision making process. While planning in a vacuum often produces documents that are impressive from the point of view of technical craftsmanship, such planning rarely impacts on decisions. Planning's reason for existence is to improve the quality of decisions.

It would appear that major hurdles have been negotiated and that it is possible to be optimistic about the future of the deinstitutionalization movement. The movement has passed through an infancy, a childhood, and a rebellious adolescence. It is now ready to embark on a mature quest for answers to the issues which have plagued it.

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